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	175376	A. BUILDING _____ B. WING _____	04/24/2012

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility reported a census of 82 residents. Based on record review and staff interview, the facility failed to incorporate the 6/17/11 Centers for Medicare and Medicaid Services (CMS) letter entitled "Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility (LTC): Section 150B of the Social Security Act" into their existing facility policy. Findings included: - The undated facility policy entitled "Resident Abuse, Neglect, Exploitation and Mistreatment" did not incorporate the information in the CMS letter dated 6/17/11. Interview on 4/23/12 at 8:48 A.M. with administrative licensed nursing staff B reported that the facility had not revised their policy since this letter came out. The facility failed to fully develop written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 226	Continued From page 1 misappropriation of resident property.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility had a census of 82 residents. The sample included 19 residents. Based upon observation, record review and interviews the facility failed to provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 (#40) of 4 residents sampled for community discharge/rehabilitation. Findings included: - Review of resident #40's Physician Order Sheet (POS) dated 3/19/12 included the resident had diagnoses that included: hypopotasesemia, hyposmolality, osteoporosis, hyperlipicemia, hypothyrodisim, dementia, fractured radius shaft closed. The resident's April 2012 Medication Administration Record included the resident had received 25 milligrams of Zoloft (an antidepressant) since 4/4/12. The resident's admission Minimum Data Set (MDS) 3.0 with an assessment reference date	F 250		

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(ARD) of 2/20/12 identified the resident scored 11 (moderately impaired cognition) on the Brief Interview for Mental Status (BIMS), total severity score of 08 out of 27 (mild depression) on the resident mood interview/9-Item Patient Health Questionnaire-9(PHQ-9), did not exhibit any behaviors, required limited staff assistance with dressing, independent with eating and required staff supervision with all other Activities of Daily Living, and had not received an antidepressant medication in the last 7 days.

The resident's MDS 3.0 admission assessment (reentry) with an ARD of 4/12/12 identified the resident was discharged to a local acute hospital on 3/28/12 and returned to the facility on 4/4/12. The MDS included the resident scored 14 (cognitively intact) on the BIMS, total severity score of 16 (moderately severe depression) out of 27 did not exhibit any behaviors, required staff supervision with bed mobility, personal hygiene, locomotion on and off of the unit, walking in the room, extensive staff assistance with transfers, limited staff assistance with walking in the corridor, dressing, eating, and toilet use, and had not received an antidepressant in the last 7 days.

The resident's cognitive status, and mood Care Area Assessment (CAA) dated 4/12/12 identified the resident cognitive status had changed, declined in mood, the resident had always been very social and now did not want to do the things he/she always liked to do, the facility staff felt it was just overwhelming for the resident and got upset if the facility pushed the resident's care plan.

The resident psychosocial CAA dated 4/12/12

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included the resident had recently moved into the nursing home, had a change in health perception, was discouraged regarding the decline and residing in the facility. The psychosocial CAA included the resident stated yes to some days he/she would better off dead since he/she was not independent anymore, and the resident started taking an antidepressant during his/her stay at a Senior Diagnostic Unit.

The resident's care plan (dated 4/12/12) included an entry dated 4/18/12 that addressed the resident's emotional well-being related to isolation, manifested by sadness, boredom and that staff would visit with the resident regarding his/her wishes and what he/she would like to do within the isolation restrictions, staff visited with the resident during care and talked with him/her about things he/she would liked to do. The care plan included a therapy staff walked with the resident outside (no frequency included), staff would take activities to the resident's room and/or set up television programs for the resident to watch.

The resident's care plan did not include medically related social services to address the resident's depression.

A Neuropsychological Evaluation and Treatment dated 4/1/12 included the resident had Increased confusion and worsening memory losses recently, had been belligerent and angry and showed wondering and/or eloping behavior since the resident had resided at the nursing facility, and the resident was admitted to a Senior Diagnostic Unit for an evaluation on 3/28/12. The Neuropsychological Evaluation and Treatment

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report included the resident's neuropsychological deficit included severe impairment in mental control, mild level of dementia, the resident's mood appeared depressed, the resident openly admitted he/she had experienced sadness, loss of pleasures in doing things he/she used to enjoy, irritabilities and a sense of hopelessness. The report also included the resident admitted he/she wished to die sometimes, felt worthlessness because he/she could not do a lot of things, experienced fatigue, sleeping disturbances, sensitivity to fatigue, and showed depressive symptoms, which appeared consistent with major depressive disorder, single episode. The report included the resident's recent anger, wandering and/or eloping behavior was likely reflective of his/her depression and difficulty in adjusting to life in a new living environment at the nursing facility. The report included the following recommendations: Recommended to live in an assisted living facility to ensure his/her safety and meet daily needs, continue anti-dementia medication treatment, and psychiatric treatment was recommended for his/her depression.

A nurse's note dated 3/27/12 timed 8:38 A.M. documented staff noticed the resident more confused and bewildered behaviors in the past 2 weeks, when staff reminded him/her of things he/she forgot, the resident got nippy and made a sad face.

A speech therapist note dated 4/18/12 timed 11:44 A.M. documented the resident continued in isolation so was seen in his/her room, the resident was very pleasant but really wanted to be able to walk in the hall.

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A speech therapist progress note dated 4/19/12 timed 8:50 A.M. documented the resident depressed and stated he/she felt depressed due to the isolation, the therapist explained how important isolation was but also validated the resident's feelings.

During the initial tour of the facility on 4/17/12 at approximately 9:15 A.M. a sign on the resident's door read for visitors to report to the nurse's station prior to entering the resident's room. During interview with licensed nurse F at that time, the licensed nurse stated the resident was in contact isolation due to Clostridium Difficile.

During interview with the resident during Stage 1 of the survey on 4/18/12 at 10:07 A.M. the resident was almost in tears and stated he/she did not feel he/she was treated with dignity and respect, people thought if they entered his/her room they would contract an illness and stated you would think I had leprosy or something. The resident stated he/she could not go out of his/her rooms for meals or to attend activities.

During interview with the resident on 4/23/12 at 11:15 A.M. the resident stated he/she was depressed related to having to stay in his/her room. The resident stated he/she would agree to psychotherapy.

During interview with Social Service Staff M on 4/23/12 at 11:00 A.M. the staff stated social services did not provide medically related social services regarding depression. Social Service Staff M stated that was the function of the nursing department. Licensed staff I (present at the time) stated the facility was aware the resident was

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F 250	Continued From page 6 depressed prior to transferring the resident to the Senior Diagnostic Unit, and the facility had not followed up on the Neuropsychological Evaluation and Treatment recommendation regarding the resident seeing a psychiatrist regarding his/her depression. Licensed staff I stated the facility did not contract with any agency/individual regarding psychotherapy and no one in the facility's proximity provided those services. Licensed nurse I stated the only treatment the resident received regarding his/her depression was the 25 milligrams of Zoloft started during the resident's stay at the Senior Diagnostic Unit. During interview with nursing administrative staff B on 4/23/12 at 11:40 A.M. the staff stated the Neuropsychological Evaluation and Treatment recommendation regarding the resident seeing a psychiatrist "fell through the crack" and the facility had not followed up on the recommendation. The facility failed to ensure that this resident assessed with moderately severe depression received medically related social services that maintained or improved the resident's mental, and psychosocial needs.	F 250		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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F 329	Continued From page 7 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility identified a census of 82 residents. The sample included 17 residents. Based on observation, record review and staff interview, the facility failed to identify appropriate Black Boxed Warnings of medications for four of the ten residents reviewed for unnecessary medications. (#92, #83, #24, #48) Findings included: - Resident #92 had diagnoses that included chronic kidney disease stage IV, congestive heart failure, atrial fibrillation, diabetes mellitus type II, hyperlipidemia, esophageal reflux, fracture of base femoral neck closed, retention of urine, benign prostatic hypertrophy without urinary obstruction, and systolic/diastolic heart failure as listed on the Physician Orders Recertification (POR) dated 3/19/12. The POR recorded the	F 329		

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resident's medication included Warfarin 5 mg./7.5 mg. alternating dose daily for atrial fibrillation, Metoprolol 25 milligrams (mg.) twice a day for congestive heart failure, and Celexa 40 mg. daily for depression.

The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/2012 recorded a score of 14 (cognitively intact) on the Brief Interview for Mental Status (BIMS) and received anti-depressant medication. The resident required extensive assist of two staff with bed mobility and transfers; extensive assist of one staff with walking in room/corridor and personal hygiene; total dependence of one staff with locomotion on/off unit, dressing, and toilet use: and set up and supervision with eating.

BlackBoxRx.com recorded the following U.S. Boxed Warnings for Warfarin: Warfarin Sodium can cause major or fatal bleeding. Bleeding was more likely to occur during the starting period and with a higher dose resulting in a higher International Normalized Ratio (INR). Risk factors for bleeding include high intensity of anticoagulation (INR greater than 4), age 65, or older, highly variable INRs, history of gastrointestinal bleeding, hypertension, cerebrovascular disease, serious heart disease, anemia, malignancy, trauma, renal insufficiency, concomitant drugs, and long duration of warfarin therapy. Metoprolol: Abrupt withdrawal not advised in patients with angina pectoris, coronary artery disease or ischemic heart disease. Severe exacerbation of angina and the occurrence of myocardial infarction and ventricular arrthymias had been reported in angina patients following abrupt discontinuation. Celexa: Patients of all

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ages who are started on therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

The care plan dated 1/27/12 and last reviewed 2/3/12 recorded Black Box Warning medications manifested by Lasix, Digoxin, Oxycodone, Coumadin, Simvastatin, Aldactone, Lopressor, Celexa. The interventions listed nursing staff monitored the side effects noted from medications, nursing staff would identify the medications by the listing on the Medication Administration Record (MAR) and the red dot on the label of the medication cassette, communicate with physicians on effectiveness of medications, and review medications with physicians every 60 days for efficacy and side effects.

Review of the facility policy/procedure for Black Box Warning recorded that Black Box Warning medications were identified by a red dot on the medication container, were identified on the MAR (side effects listed) and all staff who passed medications were educated on the definition of the Black Box Warning and advised of the content of this policy.

Review of the current POR and MAR revealed no documentation of the above listed Black Box Warnings.

An observation on 4/18/12 at 4:15 P.M. revealed resident seated in recliner in room with legs elevated, call light within reach, and oxygen per nasal cannula.

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Staff interview on 4/23/12 at 8:20 A.M. with licensed nursing staff G stated the medication cassette of medications with Black Box Warnings had a red dot placed on the cassette by the dispensing pharmacy and the MAR listed medications with Black Box Warnings.

Staff interview on 4/23/12 at 1:32 P.M. with licensed nursing staff H reported Black Box Warnings were monitored whenever a medication with a Black Box Warning was administered. He/she reported the Black Box Warning would be located in drug reference books available at nursing stations and the pharmacist could be contacted for information.

The facility failed to identify and monitor for the side effects of medications with Black Box Warnings.

- Resident #24 had diagnoses that included osteoarthritis, intestinal obstruction, hypertension, idiopathic peripheral neuropathy, right total hip, hysterectomy, colostomy, hemithyroidectomy, cholecystectomy, and right wrist fracture as listed on the 1/12/12 Physician Order Sheet (POS). This same POS recorded the resident received medications that included Percocet for chronic pain, Fentanyl patch for pain, Zoloft for depression, Cozaar for hypertension, Aspirin for prophylaxis, Levothyroxine for hypothyroidism, and Metoprolol for diabetes.

The Medication Administration Record (MAR) for 4/12 listed the following medications that had Black Box Warnings (BBW): Percocet, Zoloft, Cozaar, Fentanyl, Asa, Levothyroxine, and

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Metoprolol.

The significant change Minimum Data Set 3.0 dated 3/1/12 recorded a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact), had no delirium, a mood score of 13 (moderate depression), no behaviors, did not reject care, needed extensive staff assistance with activities of daily living except eating, and received scheduled pain medication.

The care plan dated 12/7/11 listed BBW for the following medications: Percocet, Zoloft, Cozaar, Fentanyl, Aspirin, Levothyroxine, and Metoprolol. The care plan directed the nursing staff to monitor the side effects of these identified medications, that the nurses needed to be able to identify the medications by the listing on the MAR and the red dot on the label, to work with the physician on effectiveness of the medications, and to review the medications with the physician quarterly for efficacy and side effects. On 3/1/12 the staff recorded that the goal was met (no adverse side effects noted from the medications) and that the facility would continue with the care plan.

Blackboxrx.com recorded for Fentanyl the following BBW: "This product contains a high concentration of potent Schedule II opiod agonist, fentanyl. Schedule II opiod substances have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression..."

Blackboxrx.com recorded for Metoprolol the following BBW: "Abrupt withdrawal not advised with angina pectoris, CAD or ischemic heart disease. Severe exacerbation of angina and the

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F 329	Continued From page 12 occurrence of MI {myocardial infarct} and ventricular arrythmias have been reported in angina patients following abrupt discontinuation." Blackboxrx.com recorded for Percocet the following BBW: "Oxycodone is an opiod agonist and a schedule II controlled substance with an abuse liability similar to morphine...."All patients receiving opiods should be routinely monitored for signs of misuse, abuse and addiction." Observation on 4/19/12 at 8:00 A.M. the resident ate breakfast in his/her room. The resident stated the breakfast tasted good. An interview 4/23/12 at 8:15 A.M. with licensed nursing staff G said the MAR listed the medications with a Black Box Warning, and on the individual medication cartridge there was a red dot that indicated the medication had a BBW. The staff said the facility dispensing pharmacy placed it on the cassette. The staff said they kept a BBW book study guide in the drawer at the nurses' desk that the staff used if they needed to look up what the BBW was for a particular medication, as neither the MAR nor the care plan recorded what the warning was. The staff said it was a work in progress for them. The facility failed to identify and monitor for the side effects of medications with Black Box Warnings. - Resident #48 had diagnoses that included hypothyroidism, diabetes mellitus, dysthymic disorder, personality disorder, mild intellectual	F 329		

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disability, encephalopathy, and hypertension as recorded on the 3/19/12 Physician Order Sheet (POS). This POS recorded the resident received medications that included Aspirin for anticoagulation, Lortab for moderate to severe pain, Tylenol for pain, Depakote for bipolar mood disorder, Atenolol for hypertension, Metformin for diabetes, and Effexor for depression.

The quarterly Minimum Data Set 3.0 dated 2/8/12 recorded a BIMS (Brief Interview for Mental Status) score of 8 (mild impairment), had no delirium, a mood score of 9 (mild depression), did not reject care, needed extensive staff assistance with activities of daily living except eating, and received an anti-depressant medication.

The care plan dated 12/7/11 listed the following medications had Black Box Warnings (BBW): Aspirin, Lortab, Tylenol, Depakote, Atenolol, Actos, Metformin, Efexor, and Levothyroxine. The care plan directed for the nursing staff to monitor the side effects of the identified medications, to be able to identify the medications by the listing on the Medication Administration Record (MAR) and the red dot on the label, to work with the physician on effectiveness of medications, review medications with the physician quarterly for effectiveness and side effects. The care plan did not record what the warning was for these medications.

The MAR dated 4/12 recorded BBW for the following medications: Depakote, Effexor, Atenolol, Levothyroxine, and Metformin.

Blackboxrx.com recorded for Depakote the following BBW: "Hepatic failure resulting in

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT ST SABETHA, KS 66534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 14	F 329		

fatalities has occurred in patients receiving valproic acid and its derivatives. "Cases of life threatening pancreatitis have been reported in both children and adults. Some cases have been described as hemorrhagic with a rapid progression from initial symptoms to death."

Blackboxrx.com recorded for Metformin the following BBW: "Lactic acidosis is a rare, but serious metabolic complication that can occur due to metformin accumulation during treatment. When it occurs, it is fatal in approximately 50 percent of cases. Lactic acidosis may also occur in association with a number of pathophysiological conditions, including diabetes mellitus, and whenever there is a significant tissue hyperperfusion and hypoxemia."

An observation on 4/19/12 at 3:50 P.M. direct care staff J responded to the resident's call light. The resident was ready to get up from bed. The staff used a sit to stand lift to transfer the resident to the wheel chair.

An interview 4/23/12 at 8:15 A.M. with licensed nursing staff G said the MAR listed the medications with a Black Box Warning, and on the individual medication cartridge there was a red dot that indicated the medication had a BBW. The staff said the facility's dispensing pharmacy placed it on the cassette. The staff said they kept a BBW book study guide in the drawer at the nurses desk that the staff used if they needed to look up what the BBW was for a particular medication, as neither the MAR nor the care plan recorded what the warning was. The staff said it was a work in progress for them.

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F 329	Continued From page 15 The facility failed to identify and monitor for the side effects of medications with Black Box Warnings. - Resident #83 had diagnoses that included dementia, hypothyroidism, nutrition disorder, tension headache, eye disease, macular degeneration, diabetes mellitus, and glaucoma as listed on the Physician Order Sheet (POS) dated 03/19/12. This POS recorded the resident received Seroquel, an anti-psychotic medication, 100 milligram (mg) daily for organic mental disorder with psychosis, Metformin (Glucophage), an oral anti-diabetic medication for diabetes mellitus, and Tylenol (APAP) extra strength 1000 mg twice a day for pain. The Medication Administration Record (MAR) for 4/12 listed Black Box Warnings for the following medications: Synthroid, Metformin, Enalapril, Celexa, Seroquel, and Tylenol. Blackboxrx.com recorded for Metformin the following Black Box Warning: " Lactic Acidosis is a rare, but serious, metabolic complication that can occur due to metformin accumulation during treatment. When it occurs, it is fatal in approximately 50 percent of cases. Lactic acidosis may also occur in association with a number of pathophysiologic conditions, including diabetes mellitus, and whenever there is significant tissue hypoperfusion and hypoxemia. " Blackboxrx.com recorded for Seroquel the following Black Box Warning: " Increased Mortality in Elderly Patients with Dementia Related Psychosis. Elderly patients with dementia related psychosis treated with atypical antipsychotic drugs are at an increased risk of	F 329		

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F 329	Continued From page 16	F 329		

death compared to placebo. "
Blackboxrx.com recorded for Tylenol: "
Prescription acetaminophen products to be limited to 325mg per dosage unit; boxed warning will highlight potential for severe liver failure.
Hepatoxicity: Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most cases of liver injury are associated with the use of acetaminophen at doses that exceed 4000 mg per day and often involve more than one acetaminophen-containing product. "
The care plan dated 2/24/12 and last revised 03/02/12 listed medications with Black Box Warnings as follows: Enalapril, Synthroid, Metformin, Celexa, Seroquel, and Tylenol. The care plan directed the nursing staff to monitor the side effects of the identified medications, be able to identify the medications by the listing on the MAR and the red dot label, to work with physicians on effectiveness of medications, review medications with physician every 60 days for efficacy and side effects.
An observation on 04/19/12 at 8:25 A.M. Resident sat in the dining room and was offered a medication by licensed staff O. He/She took the medication in a pill cup and swallowed the medication without difficulty with a drink of water.
An interview on 4-23-12 at 12:45 P.M. with licensed nursing staff G indicated that their dispensing pharmacy placed a red dot sticker on the pill cassettes to alert staff passing medications, that the medication had a Black Box Warning (BBW). The dispensing pharmacy listed on the bottom of each page on the MAR the BBW mediations. The staff said the dispensing pharmacy did not list the side effects beside the BBW medications on the MAR.

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F 329	Continued From page 17 The facility failed to identify and monitor for side effects of medications with Black Box Warnings.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility identified a census of 82 residents. The sample included 17 residents. Based on observation, record review and staff interview, the facility failed to identify appropriate Black Boxed Warnings of medications for four of the ten residents reviewed for unnecessary medications. (#92, #83, #24, #48) Findings included: - Resident #92 had diagnoses that included chronic kidney disease stage IV, congestive heart failure, atrial fibrillation, diabetes mellitus type II, hyperlipidemia, esophageal reflux, fracture of base femoral neck closed, retention of urine, benign prostatic hypertrophy without urinary obstruction, and systolic/diastolic heart failure as listed on the Physician Orders Recertification (POR) dated 3/19/12. The POR recorded the	F 428		

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resident's medication included Warfarin 5 mg./7.5 mg. alternating dose daily for atrial fibrillation, Metoprolol 25 milligrams (mg.) twice a day for congestive heart failure, and Celexa 40 mg. daily for depression.

The admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/3/2012 recorded a score of 14 (cognitively intact) on the Brief Interview for Mental Status (BIMS) and received anti-depressant medication. The resident required extensive assist of two staff with bed mobility and transfers; extensive assist of one staff with walking in room/corridor and personal hygiene; total dependence of one staff with locomotion on/off unit, dressing, and toilet use: and set up and supervision with eating.

BlackBoxRx.com recorded the following U.S. Boxed Warnings for Warfarin: Warfarin Sodium can cause major or fatal bleeding. Bleeding was more likely to occur during the starting period and with a higher dose resulting in a higher International Normalized Ratio (INR). Risk factors for bleeding include high intensity of anticoagulation (INR greater than 4), age 65, or older, highly variable INRs, history of gastrointestinal bleeding, hypertension, cereberovascular disease, serious heart disease, anemia, malignancy, trauma, renal insufficiency, concomitant drugs, and long duration of warfarin therapy. Metoprolol: Abrupt withdrawal not advised in patients with angina pectoris, coronary artery disease or ischemic heart disease. Severe exacerbation of angina and the occurrence of myocardial infarction and ventricular arrthymias had been reported in angina patients following abrupt discontinuation. Celexa: Patients of all

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ages who are started on therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior.

The care plan dated 1/27/12 and last reviewed 2/3/12 recorded Black Box Warning medications manifested by Lasix, Digoxin, Oxycodone, Coumadin, Simvastatin, Aldactone, Lopressor, Celexa. The interventions listed nursing staff monitored the side effects noted from medications, nursing staff would identify the medications by the listing on the Medication Administration Record (MAR) and the red dot on the label of the medication cassette, communicate with physicians on effectiveness of medications, and review medications with physicians every 60 days for efficacy and side effects.

Review of the facility policy/procedure for Black Box Warning recorded that Black Box Warning medications were identified by a red dot on the medication container, were identified on the MAR (side effects listed) and all staff who passed medications were educated on the definition of the Black Box Warning and advised of the content of this policy.

Review of the current POR and MAR revealed no documentation of the above listed Black Box Warnings.

Review of the drug regime review dated 2/22/12 did not identify the medication irregularities.

An observation on 4/18/12 at 4:15 P.M. revealed resident seated in recliner in room with legs

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F 428	Continued From page 20 elevated, call light within reach, and oxygen per nasal cannula. Staff interview on 4/23/12 at 8:20 A.M. with licensed nursing staff G stated the medication cassette of medications with Black Box Warnings had a red dot placed on the cassette by the dispensing pharmacy and the MAR listed medications with Black Box Warnings. Staff interview on 4/23/12 at 1:32 P.M. with licensed nursing staff H reported Black Box Warnings were monitored whenever a medication with a Black Box Warning was administered. He/she reported the Black Box Warning would be located in drug reference books available at nursing stations and the pharmacist could be contacted for information. An interview on 4/24/12 at 11:19 A.M. with consultant pharmacist N he/she stated that medication monitoring was completed on a monthly basis. He/she monitored medications for supporting diagnosis, monitored lab work as related to prescribed medications, monitored medications for potential drug dosage reduction. He/she alerted staff of medications with Black Boxed Warnings (BBW) and provided resources for further investigation of individual medication's BBW. He/she is not involved in the facility's protocol for alerting nursing staff of identified BBW and monitoring. The pharmacy consultant N failed to identify and report to the physician and the facility the medication irregularities.	F 428		

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- Resident #24 had diagnoses that included osteoarthritis, intestinal obstruction, hypertension, idiopathic peripheral neuropathy, right total hip, hysterectomy, colostomy, hemithyroidectomy, cholecytectomy, and right wrist fracture as listed on the 1/12/12 Physician Order Sheet (POS). This same POS recorded the resident received medications that included Percocet for chronic pain, Fentanyl patch for pain, Zoloft for depression, Cozaar for hypertension, Aspirin for prophylaxis, Levothyroxine for hypothyroidism, and Metoprolol for diabetes.

The Medication Administration Record (MAR) for 4/12 listed the following medications that had Black Box Warnings (BBW): Percocet, Zoloft, Cozaar, Fentanyl, Asa, Levothyroxine, and Metoprolol.

The significant change Minimum Data Set 3.0 dated 3/1/12 recorded a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact), had no delirium, a mood score of 13 (moderate depression), no behaviors, did not reject care, needed extensive staff assistance with activities of daily living except eating, and received scheduled pain medication.

The care plan dated 12/7/11 listed BBW for the following medications: Percocet, Zoloft, Cozaar, Fentanyl, Aspirin, Levothyroxine, and Metoprolol. The care plan directed the nursing staff to monitor the side effects of these identified medications, that the nurses needed to be able to identify the medications by the listing on the MAR and the red dot on the label, to work with the physician on effectiveness of the medications, and to review the medications with the physician

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quarterly for efficacy and side effects. On 3/1/12 the staff recorded that the goal was met (no adverse side effects noted from the medications) and that the facility would continue with the care plan.

Blackboxrx.com recorded for Fentanyl the following BBW: "This product contains a high concentration of potent Schedule II opiod agonist, fentanyl. Schedule II opiod substances have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression..."

Blackboxrx.com recorded for Metoprolol the following BBW: "Abrupt withdrawal not advised with angina pectoris, CAD {coronary artery disease} or ischemic heart disease. Severe exacerbation of angina and the occurrence of MI {myocardila infarct} and ventricular arrythmias have been reported in angina patients following abrupt discontinuation."

Blackboxrx.com recorded for Percocet the following BBW: "Oxycodone is an opiod agonist and a schedule II controlled substance with an abuse liability similar to morphine...."All patients receiving opiods should be routinely monitored for signs of misuse, abuse and addiction."

Review of the monthly Drug Regime Review dated 3/23/12, 2/27/12, 1/18/12, 12/1/11, and 11/11/11 did not identify the medication irregularities

Observation on 4/19/12 at 8:00 A.M. the resident ate breakfast in his/her room. The resident stated the breakfast tasted good.

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An interview 4/23/12 at 8:15 A.M. with licensed nursing staff G said the MAR listed the medications with a Black Box Warning, and on the individual medication cartridge there was a red dot that indicated the medication had a BBW. The staff said the facility's dispensing pharmacy placed it on the cassette. The staff said they kept a BBW book study guide in the drawer at the nurses desk that the staff used if they needed to look up what the BBW was for a particular medication, as neither the MAR nor the care plan recorded what the warning was. The staff said it was a work in progress for them.

The consultant N failed to identify medication irregulraties and failed to report to the facility and the physician.

- Resident #48 had diagnoses that included hypothyroidism, diabetes mellitus, dysthymic disorder, personality disorder, mild intellectual disability, encephalopathy, and hypertension as recorded on the 3/19/12 Physician Order Sheet (POS). This POS recorded the resident received medications that included Aspirin for anticoagulation, Lortab for moderate to severe pain, Tylenol for pain, Depakote for bipolar mood disorder, Atenolol for hypertension, Metformin for diabetes, and Effexor for depression.

The quarterly Minimum Data Set 3.0 dated 2/8/12 recorded a BIMS (Brief Interview for Mental Status) score of 8 (mild impairment), had no delirium, a mood score of 9 (mild depression), did not reject care, needed extensive staff assistance with activities of daily living except eating, and

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received an anti-depressant medication.

The care plan dated 12/7/11 listed the following medications had Black Box Warnings (BBW): Aspirin, Lortab, Tylenol, Depakote, Atenolol, Actos, Metformin, Efexor, and Levothyroxine. The care plan directed for the nursing staff to monitor the side effects of the identified medications, to be able to identify the medications by the listing on the Medication Administration Record (MAR) and the red dot on the label, to work with the physician on effectiveness of medications, review medications with the physician quarterly for effectiveness and side effects. The care plan did not record what the warning was for these medications.

The MAR dated 4/12 recorded BBW for the following medications: Depakote, Effexor, Atenolol, Levothyroxine, and Metformin.

Blackboxrx.com recorded for Depakote the following BBW: "Hepatic failure resulting in fatalities has occurred in patients receiving valproic acid and its derivatives. "Cases of life threatening pancreatitis have been reported in both children and adults. Some cases have been described as hemorrhagic with a rapid progression from initial symptoms to death."

Blackboxrx.com recorded for Metformin the following BBW: "Lactic acidosis is a rare, but serious metabolic complication that can occur due to metformin accumulation during treatment. When it occurs, it is fatal in approximately 50% of cases. Lactic acidosis may also occur in association with a number of pathophysiological conditions, including diabetes mellitus, and

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F 428	Continued From page 25 whenever there is a significant tissue hyperperfusion and hypoxemia." Review of the monthly Drug Regime Review dated 3/23/12, 2/27/12, 1/18/12, 12/1/11, and 11/11/11 did not identify the medication irregularities. An observation on 4/19/12 at 3:50 P.M. direct care staff J responded to the resident's call light. The resident was ready to get up from bed. The staff used a sit to stand lift to transfer the resident to the wheel chair. An interview 4/23/12 at 8:15 A.M. with licensed nursing staff G said the MAR listed the medications with a Black Box Warning, and on the individual medication cartridge there was a red dot that indicated the medication had a BBW. The staff said the facility dispensing pharmacy placed it on the cassette. The staff said they kept a BBW book study guide in the drawer at the nurses desk that the staff used if they needed to look up what the BBW was for a particular medication, as neither the MAR nor the care plan recorded what the warning was. The staff said it was a work in progress for them. The consultant N failed to identify medication irregulrities and failed to report to the facility and the physician. - Resident #83 had diagnoses that included dementia, hypothyroidism, nutrition disorder, tension headache, eye disease, macular degeneration, diabetes mellitus, and glaucoma as	F 428		

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F 428	Continued From page 26 listed on the Physician Order Sheet (POS) dated 03/19/12. This POS recorded the resident received Seroquel, an anti-psychotic medication, 100 milligram (mg) daily for organic mental disorder with psychosis, Metformin (Glucophage), an oral anti-diabetic medication for diabetes mellitus, and Tylenol (APAP) extra strength 1000 mg twice a day for pain. The Medication Administration Record (MAR) for 4/12 listed Black Box Warnings for the following medications: Synthroid, Metformin, Enalapril, Celexa, Seroquel, and Tylenol. Blackboxrx.com recorded for Metformin the following Black Box Warning: " Lactic Acidosis is a rare, but serious, metabolic complication that can occur due to metformin accumulation during treatment. When it occurs, it is fatal in approximately 50 percent of cases. Lactic acidosis may also occur in association with a number of pathophysiologic conditions, including diabetes mellitus, and whenever there is significant tissue hypoperfusion and hypoxemia. " Blackboxrx.com recorded for Seroquel the following Black Box Warning: " Increased Mortality in Elderly Patients with Dementia Related Psychosis. Elderly patients with dementia related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. " Blackboxrx.com recorded for Tylenol: " Prescription acetaminophen products to be limited to 325mg per dosage unit; boxed warning will highlight potential for severe liver failure. Hepatoxicity: Acetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most cases of liver injury are associated with the use of	F 428		

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acetaminophen at doses that exceed 4000 mg per day and often involve more than one acetaminophen-containing product. "
The care plan dated 2/24/12 and last revised 03/02/12 listed medications with Black Box Warnings as follows: Enalapril, Synthroid, Metformin, Celexa, Seroquel, and Tylenol. The care plan directed the nursing staff to monitor the side effects of the identified medications, be able to identify the medications by the listing on the MAR and the red dot label, to work with physicians on effectiveness of medications and review medications with physician every 60 days for efficacy and side effects.
An observation on 04/19/12 at 8:25 A.M. Resident sat in the dining room and was offered a medication by licensed staff O. He/She took the medication in a pill cup and swallowed the medication without diffiiculty.
An interview on 4-23-12 at 12:45 P.M. with licensed nursing staff G indicated that their dispensing pharmacy placed a red dot sticker on the pill cassettes to alert staff passing medications, that the medication had a Black Box Warning (BBW). The dispensing pharmacy listed on the bottom of each page on the MAR the BBW mediations. The staff said the dispensing pharmacy did not list the side effects beside the BBW medications on the MAR.
Review of the drug regimen review date 10/12/11, 11/11/11, 12/01/11, 01/10/12, 02/20/12, and 03/23/12 did not identify the medication irregularities.
04/24/12 at 11:19 A.M. An interview with Consultant N indicated that he monitors the skilled resident's medication on a monthly basis and the assisted living residents quarterly. He monitors that all medications have supporting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175376	A. BUILDING _____ B. WING _____	04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN HOME	511 PARAMOUNT ST SABETHA, KS 66534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 28 diagnoses, reviews lab work as related to medications, monitors nursing notes and doctor progress notes for possible drug dosage reducations unless it is clearly documented by the doctor that no drug dosage reducation is warranted. He alerts staff th medications that have Black Box Warnings and provides resources for further investigating those Black Box Warnings. How the facility identifies and monitors the Black Box Warnings is per the facilities protocol. The Consultant N failed to identify medication irregularities and failed to report to the physician and the facility	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 29	F 441		

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 82 residents. The facility identified 1 resident in contact isolation with Clostridium Difficile. Based upon observation, record review, and interview the facility failed to prevent cross-contamination to prevent the onset and the spread of infection when cleaning the room of the resident in contact isolation with Clostridium Difficile (C-Diff) for 1 of 1 observations.

Findings included:

- On 4/19/12 at approximately 3:15 P.M. housekeeping staff R prepared to enter the resident's room (resident in contact isolation due to Clostridium Difficile) to perform the daily cleaning. Prior to entering the room, housekeeping staff R put on a disposable gown, shoe covers, mask and gloves. Housekeeping staff R carried a squirt bottle that contained 1:9

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	175376	A. BUILDING _____ B. WING _____	04/24/2012

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F 441	Continued From page 30	F 441		

bleach solution, and a sweep type broom. Housekeeping staff swept the room, stated he/she did not have a dust pan, used his/her hands to gather the swept debris, and placed the trash in the receptacle in the resident's room. Housekeeping staff R without changing gloves, removed the broom handle and the mechanism (that holds the broom head) from the broom head, placed the broom handle on the wall in the hallway, and placed the mechanism on the hallway's floor. Housekeeping staff R did not clean the broom handle or the mechanism prior to placing them in the hallway. Housekeeping staff R using the same gloves then cleaned the headboards, tables, chairs, and other furniture in the resident's room, and bathroom with the 1:9 bleach solution. While still cleaning the room housekeeping staff S asked housekeeping staff R to give the resident a flower arrangement. Housekeeping staff R with the same gloves on, placed the flower arrangement on the resident's bedside table. After cleaning the room, housekeeping staff R randomly squirted the 1:9 bleach solution on the floor, then proceeded to mop the room in water that contained LD 40 (a cleaning agent). Housekeeping staff R confirmed the mop water did not contain bleach.

On 4/19/12 at approximately 4:45 P.M. observation revealed the container of LD 40 did not included the product killed spores. Housekeeping staff S confirmed at that time the LD 40 did not kill C-Diff spores.

Review of the facility undated C-Diff policy and procedure included the gloves must be worn at all times when working in the room or handling trash, laundry, equipment, etc, daily cleaning would be

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F 441	Continued From page 31 performed with a Clorox solution of 9:1 ration, and. the facility would mop the floor with a Clorox solution. The facility failed to prevent cross contamination to prevent the spread of infection when cleaning a room where a resident in contact isolation due to Clostridium Difficile resided.	F 441		